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[Hidden Selectivity]

Irregular Migrants and Access to Socio-Health Services in a Heated Local Context

Abstract: Irregular migrations and access to social and health services by undocumented migrants has become a very relevant issue in the Italian public discussion about migration policies in the last years. On one hand, the criminalisation of irregular migration has been feeding xenophobic policies; on the other hand, the regional law on immigration in the Region of Tuscany has been trying to put forward an alternative model. By declaring the right of irregular migrants to access basic socio-health services, the Region of Tuscany enacted a radical opposition to the National Immigration Law. In such a context, what happens when irregular migrants meet public services, and in particular, social and health services, in a local area characterised by a significant number of migrants? The following reflections deal with the municipality of Prato: since the end of the 1980s, this city has become the settlement area of a high number of migrants coming from many different countries. The paper underlines both the lack of efficacy of policies merely inspired to repressive goals and the very influential role played by operators within the public sector and non-profit associations in dealing with ambiguous, informal, and unclear domains of intervention. In a context marked by a growing disengagement of the public sector toward marginal and vulnerable people (like, in many cases, irregular migrants), the time has come to impose a new commitment for the public sector and draw a different way of considering the needs of irregular migrants.

Keywords: Irregular migrants, Socio-health services, Tuscany Region, city of Prato, operators.

Introduction

Irregular migrations and access to social and health services by undocumented migrants has become a very relevant issue in the Italian public discussion about migration policies in the last years (Finotelli, Sciortino 2009; Ambrosini 2013, Fondazione Moressa 2015).

The classification of irregular migration as a penal crime by the Italian Immigration Law (the so-called *Security Package*, L. N° 125/2008) has been feeding securitarian and xenophobic policies. At the same time, the Regional Law on Immigration of the Region of Tuscany (L.R. N.° 35/2009) has been trying to put forward an alternative model: by declaring the right of irregular migrants access to basic socio-health services, the Region enacted a radical opposition to the National Immigration Law (Rossi, Biondi Dal Monte, Vrenna 2013).

This paper aims to analyse the sociological dynamics characterising the interactions between undocumented migrants and public services. Given the changes that have occurred in the regulation framework, we have paid special attention to the comparison between the paths of access to social and health services envisaged by the law and the paths devoid of regulation.

Within this framework, we have decided to investigate the so-called *shadow zones* - the spaces of relations characterised by uncertain regulation and by the lack of clear arrangements and spaces in which migrants and operators often enact their interactions, even producing conflicting outcomes. In the following pages, we want to focus on these issues and their implications for policies.

This article is based on a research conducted in 2012 in the Tuscan city of Prato with the support of Tuscany Region. The city of Prato is a very interesting field of research for many reasons. The city is the object of a wide variety of scientific literature focused mainly on local development models and industrial districts (Becattini 2001).

With specific reference to this research, Prato is the object of the study for three main reasons: a) the historical relationship between migration dynamics and the industrial district; Prato is an industrial textile district traditionally attracting migration flows (internal in the 50s and 60s, international since the end of the 80s). Over the years, precisely due to the dimensions and the main characteristics of migratory processes, the area became a 'living laboratory', particularly interesting to study social and economic changes occurring in a local community (for an overview, see Baldassar, Johanson, McAuliffe, Bressan 2015); b) the dimension and the special nature of the foreign presence: according to official figures at march 2015 (source: municipality of Prato), foreign residents (34.468) account around 18% of total resident population (191.070); c) the lack of attention of scientific research to the specific issue of irregular migration. In fact, irregular migration settled in the local area following the traditional features highlighted by the current literature: self-exploitation, tax evasion, poor safety conditions, informal regulations and very long working times (Bracci 2012).

Methodology

In terms of research method, our choice has privileged the use of qualitative techniques, which have made it possible to speak directly to migrants and operators. On one hand, we have reconstructed the main ways in which the interaction between operators and migrants takes place, highlighting the access paths, their links with informal and community networks and the nature of the relationship between services and undocumented users. On the other hand, we have collected and analysed the life stories of a significant number of migrants devoid of residence permits (but with relevant connections with the services) to understand if, and how, some invariants can emerge from their stories.

Irregular migration is by definition very difficult to grasp from a solely quantitative point of view and has an internal complexity that is impossible to recover otherwise.

Moreover, due the diversity of management and organisational models, socio-health services are poorly standardised. The different position of the actors involved in the research has required the adoption of two distinct tools to perform interviews (25 in-depth interviews: 15 operators and 10 migrants): the first one, with regard to migrants, has focused attention on the main "turning points" during the migration process; the second one, with regard to operators, has focused on the functioning of the more or less structured institutional and territorial networks.

The two interview discussion guides were tested; then, a handbook for the interviewers was drafted. In order to overcome the problems of finding subjects to interview, a series of meetings have been conducted with some local stakeholders (operators, professionals, leaders of the main migrant communities in the area) who provided a useful set of information.

Results

The collected life stories can be divided into two groups. We can define them as either Inserted and Destituted. The former have a decent socio-economic condition, quite well-working social networks and a passable cultural level; the latter have harsher socio-economic conditions, no family/kinship networks, and lower cultural standards.

The *Inserted* can combine social capital and cultural capital in order to cope with their main difficulties (typically, housing and work). On the other hand, the *Destituted* show a relevant correlation between a low availability of relational resources, poor cultural level, and marginality. They also present a lower capacity to redefine their migratory experience along its unfolding.

Knowledge of language influences the possibility to increase 'high quality' social capital: by allowing the *Inserted* to maintain more frequent connections with Italian friends or acquaintances, it increases their ability to catch the opportunities offered by the context (job or housing opportunities, but also chances related to juridical status, as the possibility to benefit from a regularisation). On the contrary, the *Destituted*, even if they have been staying in Italy for long time, are in a vicious circle: The lack of knowledge of language limits their possibilities to take advantage of regularisation proceedings, and their condition of being undocumented feeds further marginalisation

and social exclusion.

The interaction between *meso-* and *macro-* factors guides the access to services and their use by undocumented users. Informal networks and *word of mouth* mould the encounter between undocumented migrants and services well before it happens. As regards the *Inserted*, the availability of reliable information about the health supply services and a higher capacity of orientation favour the pertinence between health demand and health supply. On the contrary, the *Destituted* access the services much more often with improper demands: The lack of informative resources and the idea that the emergency room of the hospital is the only place to turn to are two aspects that impede the fruition of adequate care paths.

The emergency room works in a proper way, even if it deals with many critical situations. This service also carries out a vicarious function when the user's clinical problem cannot be easily detached from his or her social disadvantage, and this often happens when the user belongs to the group that we have defined as *Destituted*. In these cases, when the emergency room is the only accessible service, the difficulty to set up different and more articulated care paths becomes clear. Social services cannot do anything, save for rare exceptions; the connection with territorial services is absent, since the emergency room activity ends after having supplied urgent care and possibly the hospitalisation. Even if hospitalisation is not clinically needed, the emergency room can resort to *social admission* (the postponement of the discharge) when the user's social condition is harsh and cannot be addressed to social services (in the case of undocumented migrants, social services are inaccessible because they do not have a permit of stay). In any case, whether the 'social admission' ends or it is not possible, the result is that the user is discharged and turns out to be devoid of any kind of social support.

The absence of informative feedback from the external context makes the emergency room an excellent *blind service*, able to manage numerous critical issues (even not strictly of clinical sort) but with no information about what happens after the user discharge. These structural limitations have the most negative effects when the undocumented user addressing the emergency room has a scarce amount of personal 'protective factors' (social capital and cultural capital).

The special clinic for the undocumented (the so-called STP clinic, where STP means *Straniero Temporaneamente Presente* or Temporarily Present Foreigner) represents both the qualities (*in primis* the possibility to supply basic and primary health care services) and the shortcomings of the observed system. The paths for accessing the clinic are numerous: Information about the service can be given by friends or kin, by the emergency room or by associations and organisations operating in the Third Sector. Yet, interviews display migrants' low acknowledgment of the rights that they can enjoy. This deficiency is worsened by migrants' fears regarding their undocumented status.

Access to social services is not possible for undocumented migrants. In a few special cases, they can access such services in a 'tangential' way; for instance, one can have a temporary permit of stay if his or her child suffers from a bad illness. In most of these cases, access to social services is mediated by the operators of the organisations (public institutions or voluntary associations) that help the undocumented migrant apply for these special permits of stay; but the take on responsibility made possible by this special path quickly ends (unless it is possible to jump on the bandwagon of regularisation). In spite of whatever kind of social and health path onset, both for adults or children, the deadline of the permit of stay interrupts the connections with social services and pushes the users back to the uncertainties of undocumented status.

More generally, the management system of irregular migrations continues to be affected by a deep divide between principle statements and *de facto* situation (Ambrosini 2013). In practice, this divide is filled by the operators: they supply services not only filling the gaps in regulation, but sometimes they also act against the basic assumptions of the laws in force.

The *criminalisation of irregular migration* has not left any trace on the daily routines of the operators. They have rapidly set up adaptive strategies to balance respect of the law with service delivery to undocumented migrants, particularly by exploiting the ambiguities of regulation. The operators have made up an informal network - a niche moulded by the *community of practices* - which has spread and socialised these strategies. On its turn, voluntary associations have immediately and explicitly declared their unwillingness to enforce the law, underlining that the third sector has no obligation to supply its services solely to regular migrants.

The operator's increasing discretionary power, though as a whole having a positive effect, discloses some critical

issues as the tendency to personalise the supply (Barberis, Boccagni 2014). Moreover, it poses another serious problem: Given the scarce amount of low threshold services, the satisfaction of basic social and health needs of undocumented migrants depends almost entirely on multiple middleman; and between these middleman, the assessment of needs made by operators of the third sector is becoming more and more relevant.

Policy indications

Irregular migration is for Italy and Europe a structural phenomenon (Düvell 2009; Martiniello, Rath 2010; Triandafyllidou 2010). In the wake of this assumption, our research results underline three main policy indications:

1. *The inaccessibility of social services*. In order to reaffirm the universalistic principle characterising the Italian and Tuscan socio-health system, it is necessary to frame irregular migration as a peculiar aspect of the broader set of the marginality phenomena. Starting from the need to face the problem of neglected primary needs, the idea of ensuring and entitling a base of essential social rights becomes a segment of policies aimed at coping with the more general problem of national and regional *welfare* shortages.

The limits related to welfare provisions may be understood when one considers social provisions (services or subsidies) requiring the stability of migrants' stay (presumption *ipso facto* excluded for the undocumented), but such limits are harmful for basic provisions aimed at answering fundamental needs (a roof to sleep under and a something to eat). For health needs intended in a strictly clinical meaning, the *essential and urgent* answer continues to be guaranteed by the law actually in force; the same cannot be said about basic social needs. It is clear that not fulfilling these needs triggers both a gradual deterioration of irregular migrants' health conditions and an increasing pressure on socio-health services; and that is precisely the reason why the regional law has posed the issue to extend *essential and urgent* provisions to undocumented migrants in the social sector as well (Passaglia 2013).

This fact is extremely relevant for in many cases (we have previously mentioned the emergency room and social services), the supportive network breaks and returns the undocumented migrant to a destiny of marginalisation. The two most important policy perspectives that may bridge the gap are: a) improving the connection between low threshold services (soup kitchens, charitable organisations distributing clothes, and so on); and b) designing projects directed to ensure continuous access to socio-health services along the time. Both perspectives imply a specific reflection on the relations between public sector and third sector, which is the argument of the next point.

2. *The third sector and the public sector.* This research highlights the fundamental support provided by voluntary associations. Yet the actual arrangement of the relationship between third sector and the public sector draws attention to some features that deserve critical reflection.

In Tuscany (and more generally in Italy) the third sector often provides services in domains not covered by the public sector, and this does not only happens with interventions for undocumented migrants. In this particular case, it is apparent that the public sector grants the third sector a *de facto* mandate. Two associations (named Centro La Pira and Caritas Diocesana) provide indispensable support to the *Destituted* and are the only ones accessible in Prato. The take-in charge of these migrants occurs entirely within the network of third-sector organisations; both the search for a job and the possible enjoyment of a regularisation depend on the nature of these networks. This basically self-sufficient logic (inspired by the principle of charitable assistance) is the consequence of the mandate granted by public institutions to these organisations.

It may be quite obvious that the third sector is the front line for the primary needs of undocumented migrants. But this tacit division of tasks represents an implicit reception of the welfare retrenchment as the only possible perspective (Bracci, Cardamone 2005). To avoid this perspective, it is necessary to ensure centrality and resources for public policy planning.

Other research focused on migrants' access to socio-health services agree in underlying the need to improve the communication tools and in particular, the quality and accuracy of information provided to the users (Nuti, Maciocco, Barsanti 2012). Migrants' family and kinship networks cannot become the way to balance the lack of public interventions directed to enhance the existence and working principle of services. As we have noted above regarding the basic distinction between *Inserted* and *Destituted*, these resources are present to very different degrees:

The implicit option to exclusively rely on individual assets implies an assumption of a logic of *passive subsidiarity* (Kazepov 2010). This would necessarily strengthen inequalities between a native population and migrants and within migrant communities. Friends or kinship networks or supportive charitable organisations can surely be an important tool to improve the conditions of many undocumented migrants, but bearing on them and on the *de facto* mandate in favour of the third sector must not become an excuse for the public sector to discharge the task of deploying effective policies.

3. *Research perspectives*. Policy planning must take into account new possible strands of research; it is highly recommended to enhance the broad range of analysis focused on health inequalities, still not widespread in Italian social research. The social cost of health inequalities should be the focal point of this new strand of research: It would mean to design and carry out research based on the use of quantitative parameters, thus seeking to highlight the economic cost of lacking, deficient or improper interventions and more generally, the economic consequences of health inequalities (World Health Organization 2013).

The economistic approach dominating the debate about the access to health provisions must be upset. These discussions rarely recall what has already been, for a long time, a very relevant issue for investigations regarding health inequalities: the extended and economically ruinous effect of care shortages.

A study carried out in the United States estimated direct (provisions) and indirect (lack of productivity, wage loss, days of work lost, premature deaths) related to health inequalities of more disadvantaged populations. In 2006, US health expenditures were over $2.2 trillion (16% of gross domestic product); between 2003 and 2006, the combined costs of health inequalities and premature deaths in the United States were $1.24 trillion (more than the gross domestic product of India, the world's 12th largest economy in 2008). In the same period, more than 30% of direct medical costs faced by African Americans, Hispanics, and Asians were excess costs resulting from health inequalities: Eliminating health disparities for minorities would have reduced direct medical care expenditures by $229.4 billion (La Veist, Gaskin, Richard 2009). Another study carried out in Switzerland among asylum seekers analysed the direct and indirect costs of language barriers: Asylum seekers who used an interpreter cost the system more, since they received more health care; but patients who used interpreters made a lower number of visits than patients who could not overcome the language barriers.

As the study asserts,

> the presence of an interpreter makes it possible to reach an effective solution after fewer visits. And although the resulting increased provision of health care drives costs up in the short term, it is very likely that suboptimal problem solving across language barriers without an interpreter leads to increased costs in the longer term because the patient's health problems are unlikely to be resolved. (Bischoff, Denhaerynck 2010: 6)

Studies and research on health inequalities provide an unusual point of view regarding the issue under discussion. As La Veist et al. clearly assert, «usually we think of change as coming with costs, that doing something will cost more than doing what we are accustomed to doing. But in the case of health inequalities, doing nothing has a cost we should not continue to bear» (La Veist, Gaskin, Richard 2009: 6).

Conclusion

The adoption of the *Security Package* has triggered a large debate focused on the boundaries of social citizenship. The general statement of the Italian Constitution (the right to health for all the people, Article 32), has again been put into question, recalling the necessity to balance the principle of universality of human rights with the pragmatic urgency of selectivity. We think that going back is wrong. The extension of essential and urgent health services to undocumented migrants is a definitively clarified issue: it makes unnecessary the dispute between universalism and selectivity. The attempts of the *Security Package* to remove the possibility for undocumented migrants to access health care services have been rejected as a result of a strong mobilisation of associations and health care providers. This mobilisation has showed how widespread the sensitivity is toward a universal and inclusive access to health.

Consensus on these principles is widespread at the European level as well, at least among health operators. A group of 113 experts from 16 European Union countries (including Italy) has identified eight general principles

aimed at improving health care policies for migrants. Two of these principles include the need to more effectively connect services between themselves and the external setting in order to facilitate access to care for all migrants (Devillé et al. 2011).

The most critical point is the access to a basic level of social benefits, but as the judgment of the Constitutional Court regarding the Tuscany regional law has stated (Judgment No. 269/2010), it is legitimate to protect undocumented migrants' fundamental rights in order to impede their further marginalisation. The attack against inclusive and universalistic policies takes place on the grounds of financial resources, and it reveals the political nature of the debate. The representation of undocumented migrants as *usurpers of resources* appears particularly dangerous in times of crisis, contraction of the welfare state and neoliberal and austerity policies. In this framework, selectivity principles have often been adopted to limit migrants' rights (Manconi, Resta 2010).

Our research has confirmed that the expectation of amnesty is the main way out of the condition of irregularity. The obsessive attention dedicated by Italian law to the discipline of irregularity, clearly intended to avoid the limits posed by the European Union, has not helped to develop an effective capacity to properly manage the phenomenon. Some years after its approval, the national law criminalising irregular migrants is 'dismantled': One of the most important steps in the process of weakening the new law was Judgment 245/2011 of the Constitutional Court, which declared 'unconstitutional' the regulation that prevented marriage to foreigners without a residence permit.

In such a context, it appears unrealistic to imagine that local policies can play an effective role in shaping a reasonable and comprehensive framework for irregular migration issues. The uncertain regulation of Italian migration policies (Ambrosini 2012) strongly limits the capacity of local authorities and local actors taking care of social and health needs of undocumented migrants to intervene properly and effectively. It is urgent to adopt, at a national level, a new regulation model based on opposite principles with respect to the ones which represented the pillars of the policies enacted in the last 15 years (see Table 1: sketching the recommended transition).

First, it is necessary to introduce flexible mechanisms of regulation; for example, paths of regularisation and expulsion, which could be activated on a *case-by-case basis*. They would represent the only reasonable way to give a practical response to the conceptualisation of irregularity as a mobile status and not as a static condition (Koser 2010). It is also essential to redefine the relations between the public sector and the third sector, trying to overcome interactions based on the principle of the *de facto* mandate (the role of guidance played by the public system must be effective). Finally, it is not possible to disregard the necessity to continuously and systematically finance the health system policy planning. The principle of open access to *essential and urgent* care for the undocumented still stand in the National Law, but it is difficult to predict how the universalistic model that inspires that principle can withstand the populist assaults in a context marked by a deep crisis and the continuous delegitimisation of the public system.

Before concluding, it appears necessary to turn our gaze to the European dimension. European policies on immigration are stalled. More generally, the idea of a social Europe seems to have been exhausted and overwhelmed by the winds of the crisis and the ruling technocracies devoted to austerity policies. With regard to migration processes, the lowest common denominator of European policies remains the fight against irregular immigration (it suffices to see the growing role played by the Frontex agency; see: Mezzadra 2015).

That said, it is precisely at the moment in which the crisis becomes more intense that we must reaffirm the need to promote a European public space as an ideal space for discussing the possible ways out of the crisis based on alternative visions to nationalistic egotism. The democratic deficit of Europe is not, of course, only an institutional problem. It is around an issue similar to the one addressed in these pages, and more generally, around the chance to build a European public sphere capable of portending a social Europe other than the current, that we will measure the ability to build an open and inclusive model, a model also able to answer to the basic needs of people who work and live in our countries, but not in compliance with the rules concerning the permit of stay.

Table 1. A sketch of the recommended transition

	Model formally in force	*Model substantially in force*	*Recommended model*
Guiding principle	Securitarism	Voluntarism	Effective regulation
General framework	Repression, criminalisation	Recurring amnesties and regularisations, informal regulation	Flexible regulation (permanent regularisation mechanisms, expulsions on a *case by case* basis)
Resources	Focused on repression (high level of spending for law enforcement and the judiciary branch, *CIE* [identification and expulsion centres], rejections); scarce amount for social policies, *de facto* mandated to the third sector		Focused on fundamental social rights
Public sector's role	Unbalanced on the repressive side as far as it concerns national government bodies; subrogate role (nor organised neither sufficiently financed) as far as it concerns local government bodies		Policy planning, effective regulation of entries, continuous and reliable financing of social policies
Third sector's role	Integrative of national government duties in the field of administrative proceedings related to the entry system; holder of the *de facto* mandate for social policies		Collaboration/support

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